



Canada Border
Services Agency

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After Incident Report

Suicide at the Niagara
Detention Centre

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Background

1. Overview of the CBSA's Immigration Detention Program

In order to protect the safety, health and security of Canadians and the integrity of our border, the *Immigration and Refugee Protection Act* permits the CBSA to detain individuals.

When making detention decisions, CBSA officers are guided by Canada's immigration laws and regulations, as well as by CBSA's detention guidelines and national standards.

The detention guidelines contained in Enforcement Manual Chapter 20 require officers to consider all reasonable alternatives before detaining someone for immigration purposes. In fact, the CBSA relies upon a variety of alternative measures to detention when appropriate, allowing a person to be released under specific terms and conditions, such as deposits and guarantees and reporting requirements.

Pursuant to the *Immigration and Refugee Protection Act* (IRPA), detention can occur when:

1. A CBSA officer has reasonable grounds to believe that the person is inadmissible and:
 - could pose a danger to the public;
 - is unlikely to appear for immigration proceedings; or
 - identity has not been established.
2. A CBSA officer has reasonable grounds to suspect, at a port of entry, that the person is inadmissible for security reasons, violating human or international rights, serious criminality, criminality or organized criminality.
3. It is necessary to complete the immigration examination.
4. A foreign national is designated as an irregular arrival by the Minister of Public Safety.

Detention decisions may be reviewed by the CBSA up to 48 hours after the person was detained. The CBSA may release the person and impose conditions for their release. After 48 hours, detention is reviewed by the Immigration and Refugee Board (IRB), an independent quasi-judicial tribunal. Detention is then reviewed seven days and every 30 days thereafter. A different detention review schedule exists for designated foreign nationals. In these cases, detention is mandatory and detention reviews take place within 14 days, then every six months. Detention will continue until a final positive decision is made by the IRB on a refugee claim, or until release is ordered by the IRB or the Minister of Public Safety. Excluded from the mandatory detention are foreign nationals under the age of 16.

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People are detained in either a CBSA-run immigration holding centre (Laval, Quebec; Toronto, Ontario; a short-term facility in Vancouver, British Columbia) or in a provincial correctional facility.

Minors are only ever detained as a last resort taking the best interests of the child into consideration. Minors are generally referred to child welfare agencies or, as a last resort, held in CBSA IHCs.

In IHCs, males and females are separated and, when accompanied children are detained they are placed with one of their parents or guardian.

As detaining authority, the CBSA is responsible for informing those detained of their legal rights such as: the reason for the arrest and detention; the right to obtain counsel; the right to contact their embassy or the United Nations High Commissioner for Refugees (UNHCR).

For the operation of its IHCs, the CBSA maintains national detention standards that conform, to the greatest extent possible, with international protocols. National detention standards include, for example, a daily minimum of one hour open air exercise, free local telephone calls, access to a qualified religious representative upon request, and special meals provided for medical, dental or religious reasons.

Detainees have access to medical services as required and as a result of their detention, qualify for the Interim Federal Health Program if unable to pay for essential treatment, or are otherwise covered under provincial health care programs.

2. Overview of CBSA Use of Provincial Detention Facilities

The CBSA retains responsibility for all CBSA operations of its detention facilities and the care and control of persons detained under the *Immigration and Refugee Protection Act* (IRPA).

The CBSA relies on provincial correctional facilities to detain higher-risk detainees (for example, those with a violent criminal background); lower-risk detainees in areas not served by a CBSA IHC; and for those detained for over 72 hours in the Vancouver area. The CBSA detains lower-risk individuals in an immigration holding centre (IHC) where available.

Determining Suitable Facilities

Immigration detention is always considered a measure of last resort. Where risks can be mitigated, the CBSA may consider alternatives to detention such as release with conditions: in-person or telephone reporting requirements, and/or a cash bond, and/or a guarantee.

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Detention is an enforcement tool to ensure the safety, health and security of the Canadian public and therefore, where risks cannot be mitigated, the CBSA will hold, in a provincial facility, high-risk detainees who may pose a risk to public safety, as well as low-risk detainees in areas where there are no IHCs. The CBSA works closely with its provincial correctional partners to minimize interaction, to the fullest extent possible, between immigration detainees and individuals detained for criminal reasons.

In order to support officers and to consistently measure detainee risk, the CBSA has developed a standardized detention risk assessment tool. The National Risk Assessment for Detention (NRAD) implemented on September 24, 2014, establishes a standard definition of risk (high, medium and low) for individuals being considered for detention. Vulnerable populations such as minors, pregnant women, victims of human trafficking and the elderly, generally fall within the low risk category. These individuals may be released into the community with conditions as long as there are no aggravating factors which cannot be mitigated. The national procedures for the implementation of the NRAD require a reassessment of every detained case at least every 60 days after the initial risk assessment. This process provides for regular monitoring and reassessment of the level of risk of each detained case taking all new information into account, and includes consideration of alternatives to detention.

Immigration Detention in Ontario Provincial Facilities

On January 21, 2015, the CBSA signed a detention agreement with the Province of Ontario's Ministry of Community Safety and Correctional Services, governing the use of provincial correctional facilities for the detention of individuals pursuant to the *Immigration and Refugee Protection Act* (IRPA).

The agreement includes provisions for detention and transfer of a detainee to a provincial facility, terms and conditions of detention such as detainee medical care, telephone access, access to legal counsel or other representatives, access for international monitoring bodies such as the Canadian Red Cross and the UNHCR and for the exchange of information.

Program Integrity and Independent Monitoring

The CBSA strives to maintain the highest national standards for program integrity and oversight of its detention program. Its established quality assurance program, as well as numerous internal and external audits and evaluations, ensures that the CBSA consistently strives to meet national detention standards and international protocols.

The Canadian Red Cross, an independent and non-profit organization which promotes humane treatment of immigration detainees and respect of human rights and dignity, monitors CBSA compliance with national and international standards (i.e., IRPA, Canadian

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Charter of Rights and Freedoms, Convention on the Rights of the Child, UN Refugee Convention, and UNHCR Detention Guidelines) pursuant to a 2006 Memorandum of Understanding.

The CRC regularly visits detention facilities (both CBSA and provincial facilities) to monitor: treatment of detainees (by staff or other detainees); conditions of detention; ability for detainees to contact and maintain contact with family members; and legal safeguards. In 2013-14, the Red Cross carried out a total of 49 detention monitoring visits nationwide including 30 visits to provincial detention facilities.

The goal of the Red Cross is to encourage improvements to detention conditions and promote the rights of detainees. In addition to doing so via regular meetings with the CBSA, the CRC does so more formally through its annual report on detention monitoring activities in Canada. The CBSA provides the CRC with a response to each annual report recommendation with a view to improving the detention program and ultimately the detention environment for all persons detained pursuant to the IRPA.

At the same time, the CBSA regularly consults stakeholders and NGOs, such as the UNHCR, about detention issues and takes their recommendations into account as a means to continuously improve detention conditions.

3. Governance

Upon notification of a significant incident involving death in custody, the CBSA's After Incident Review Working Group (AIRWG) composed of directors-general at Headquarters will engage the relevant regional director and/or regional director general. Initial focus of activities is to guide and ensure the completion at the regional level of a regional report that sets out clearly and factually the details of the incident. Should specialised lines of support or investigation be required, the AIRWG assists the region in ensuring that specialists are available to facilitate due diligence. Upon receipt of the regional report, AIRWG reviews the report, any documentation deemed necessary to ensure completeness of the record of the incident, and the regional management action plan. Once complete, the working group assesses whether appropriate national policies, guidelines and directives have been adhered to in relation to the incident and what remedies, if any, may be required. This assessment would be delivered in the form of an After Incident Report or Memorandum and may include a management action plan to address the report's recommendations. The After Incident Report is then presented to the Vice-President chaired Incident Management Working Group (IMWG) for review, consideration and direction. The IMWG ensures full implementation of the management action plans and reports to the President.

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4. Summary of Incident

On September 22, 2014, U.S. citizen, Mr. Joseph Charles Todd Dunn attempted to commit suicide while in provincial custody at the Niagara Detention Center. His death took place in hospital on September 27, 2014. A detailed case chronology, including facts surrounding the incident is outlined in the *In Custody Death After Incident Review* (Annex 1) prepared by Southern Ontario Region (SOR).

Key Observations and Recommendations

Detention services in most regions outside of Montreal, Vancouver and Toronto are provided by the provincial correctional services. When a detainee is placed in the custody of a correctional facility, the provincial authority is responsible for 24/7 monitoring of the detainees held within their facility. While the CBSA is ultimately responsible for the care and control of all detainees, the CBSA establishes agreements with provincial authorities to ensure that the care and custody of immigration detainees is aligned with domestic obligations, including the *Canadian Charter of Rights and Freedoms*, and as closely as possible to international best practices and CBSA's national detention standards. These arrangements are often articulated in writing through a formal Memorandum of Understanding.

The following key observations and recommendations are based on the *In Custody Death After Incident Review* (Annex 1) prepared by SOR Region – and discussions stemming from the national CBSA Directors General-led After Incident Working Group. The recommendations relate primarily to:

- Governance
- Policies
- Operational Procedures
- Training

Observation #1:

The analysis in the regional report notes that at the time of the incident, detention services provided by the Ontario provincial correctional authority were covered under a 2002 Memorandum of Understanding (MOU) between Citizenship and Immigration Canada and the provincial authority. Based on the chronology of events, it was also noted that there was a 6-hour delay in the province notifying the CBSA that an incident and medical emergency involving an immigration detainee had occurred. The MOU did not implicitly or explicitly address notification procedures and therefore processes and procedures were compliant with the terms of the agreement in place at the time. A new Agreement was under development at the time of the incident.

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Developments since the incident:

On January 21, 2015, the Agreement with Ontario was finalized. The Agreement between the Province of Ontario's Ministry of Community Safety and Correctional Services and the CBSA, governs the use of provincial correctional facilities for the detention of individuals pursuant to the IRPA. The Agreement brings clarity to important issues of detention and transfer of a detainee to a provincial facility. It clearly identifies that should an immigration detainee require emergency medical care the CBSA is to be notified immediately (*clause 2.11 of Agreement at Annex 3*). It also outlines terms and conditions of detention such as detainee medical care, telephone access, access to legal counsel or other representatives, access for international monitoring bodies such as the Canadian Red Cross and the UNHCR and for the exchange of information such as detainee name, gender, date of birth, court reports, known cautions like mental instability, violence, security risk and reports of misconduct while in detention.

Observation #2:

The AIRWG noted that the report identified the lack of clarity regarding the information that was communicated by the CBSA about Mr. Dunn's medical/mental well-being to the security company responsible for transportation of the detainee and in turn to the provincial detention facility upon delivery. Unrelated to the Dunn incident, two days after the death of Mr. Dunn on September 24, 2014, the CBSA issued an operational bulletin expanding the application of the requirement to complete the detainee medical form. The new medical directive outlined in the bulletin requires arresting and detaining officers to complete the medical form prior to transporting a detainee to an admitting facility and to provide the facility with a copy of the form upon admission. In addition, on September 24, 2014 another operational bulletin was issued related to the notification protocol regarding the death of an individual detained pursuant to the IRPA. Although this protocol was not in place at the time of the incident, the region did take steps consistent with the protocol. Through this review process however, national headquarters detected a gap in the CBSA protocol in that notification procedures in the case of a serious or grave injury are not currently captured in the operational bulletin. In addition, it was noted that while the mutual exchange of information is provided for in the agreement with Ontario under sections 9.3 and 9.4, the related medical information agreement (listed in Schedules A and B of the agreement) has not yet been developed.

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Recommendation #1:

The CBSA "notification protocol regarding the death of an individual detained pursuant to the IRPA" should be revised to include notification procedures for cases of grave or serious injury of a person in custody. The updated protocol should be renamed appropriately and reissued by way of an operational bulletin.

Recommendation #2:

It is recommended the CBSA develop a medical information sharing agreement on a priority basis with Ontario as outlined in Schedules A and B of the current agreement; and, include medical information sharing provisions in other provincial agreements.

Observation # 3:

The AIRWG has noted that while the Agency has incident review protocols in place to review all serious injury or death in custody, CBSA has no access to or standing with provincial correctional authorities to receive pertinent information or reports on provincial post-incident reviews.

Recommendation #3:

It is recommended that CBSA works with provincial correctional authorities to ensure sharing, in confidence and in a timely manner, of pertinent incident-related information that may impact CBSA Detention Program decision-making and policy development.

Observation #4

In the review of officer's records in relation to the incident it was observed by SOR that officers' notes were not complete nor made in a timely manner.

Recommendation #4

It is recommended that staff be reminded of the need for independent note-taking and preparing notes in a timely manner. Previous shift briefings on this subject should be re-circulated nationally.

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Observation #5

As observed at the time of the incident, officers were not provided enhanced training on suicide and self-injury and on mental health awareness.

Recommendation #5

It is recommended that formal training be developed and provided to staff on suicide/self-injury and mental health awareness.

Conclusion

As a result of its internal review of the incident, the Southern Ontario Region has addressed as many of the identified issues that were within their authority to undertake. The recommendations identified above are put forward in good faith to close any gaps in national policies and guidelines that may persist. Should the Agency concur, the recommendations made in this report will be implemented in 2015-2016 (See Management Action Plan – Annex 4).

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Annex 1: Regional Incident Report: *In Custody Death After Incident Review*

Annex 2: Regional Management Response and Action Plan

Annex 3: Canada-Ontario Detention Agreement

Annex 4: Management Action Plan



MANAGEMENT RESPONSE AND ACTION PLAN FOR THE INCIDENT AT THE NIAGARA DETENTION CENTRE (NDC)

OVERALL MANAGEMENT RESPONSE

As a result of the incident at the NDC on September 22, 2014, the Southern Ontario Region initiated an internal review of its operations to assist in identifying procedural, training and operational improvements to strengthen the detention program in the Southern Ontario Region.

The national CBSA Directors General-led After Incident Working Group reviewed the regional review titled "*In Custody Death After Incident Review Joseph DUNN*" resulting in the approval of five recommendations. The recommendations and actions taken are intended to strengthen the CBSA detention procedures and practices.

RECOMMENDATION 1

CBSA employees should be reminded of the need for independent note-taking and preparing notes in a timely manner. Previous shift briefings on this subject should be circulated again.

MANAGEMENT RESPONSE

Regional management issue a reminder to all staff to ensure notebook and reports are based on independent observations in a timely manner.

MANAGEMENT ACTION PLAN	STATUS	COMPLETION DATE
1.1 Re-issue regional Shift Briefing with respect to notebook entries and reporting requirements to SOR employees.	Completed	March 6, 2015
1.2 The Southern Ontario Region will provide Operations Branch – Border Operations with material for preparation of a national operational bulletin reminding CBSA personnel of the requirement to ensure documents and forms are completed properly and signed by the author.	Completed	March 6, 2015
1.3 Complete Intelligence Management System (IMS) entry for the DUNN incident to document sequence of events.	Completed	March 6, 2015

September 23, 2015



RECOMMENDATION 2

Review of document transfer processes between the CBSA and G4S during the transfer of custody should be completed.

MANAGEMENT RESPONSE
The Southern Ontario Region will ensure that document transfer processes between the CBSA and the G4S security contractor are reviewed to ensure compliance with Detention Risk Assessment directives that were implemented on September 24, 2014.

MANAGEMENT ACTION PLAN	STATUS	COMPLETION DATE
2.1 The Southern Ontario Region will engage Management of G4S security to conduct a review of CBSA Directives relating to detainee health and risk assessment processes to ensure G4S are adhering to CBSA directives.	In progress	September 30, 2015

RECOMMENDATION 3

The MOU with MSCSCS should be revised to clearly outline under which conditions that the MCSCS must immediately notify the CBSA.

MANAGEMENT RESPONSE
The Southern Ontario Region will collaborate with Enforcement and Intelligence Programs Directorate to amend the MOU with the MCSCS in order to address the requirement to ensure timely notification of the CBSA when a health or safety issue is identified involving a CBSA detainee.

MANAGEMENT ACTION PLAN	STATUS	COMPLETION DATE
3.1 The Southern Ontario Region will collaborate with the Enforcement and Intelligence Programs Directorate (EIPD) to initiate a change to the MOU with the MCSCS to ensure immediate notification of the CBSA when a detainee is seriously ill, gravely injured or deceased.	In progress	March 31, 2016

September 23, 2015

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RECOMMENDATION 4

The CBSA should continue to ensure that operational bulletins are reviewed at regular intervals.

MANAGEMENT RESPONSE
The Southern Ontario Region will ensure that employees and managers are reminded to review CBSA operational bulletins on a regular basis through a regional shift-briefing.

MANAGEMENT ACTION PLAN	STATUS	COMPLETION DATE
4.1 The Southern Ontario Region will issue a shift briefing to employees and managers to ensure that CBSA operational bulletins are reviewed on a regular basis..	Completed	August 25, 2015

RECOMMENDATION 5

Formal training should be developed and provided to staff on suicide/self-injury and mental health awareness.

MANAGEMENT RESPONSE
The Southern Ontario Region will provide mental health and suicide/self-injury training to employees engaged in the arrest or detention of clients.

MANAGEMENT ACTION PLAN	STATUS	COMPLETION DATE
5.1 The Southern Ontario Region is providing mental health awareness training to employees engaged in the arrest/detention of clients prioritizing delivery to employees in the Enforcement and Intelligence Operations Division. A pilot course was provided by the Windsor police and subsequent courses will continue to be delivered	In progress	March 31, 2016

September 23, 2015



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NHQ MANAGEMENT RESPONSE AND ACTION PLAN INCIDENT AT THE NIAGARA DETENTION CENTRE (NDC)

OVERALL MANAGEMENT RESPONSE

Following the regional review of the incident at the Niagara Detention Centre (NDC) on September 22, 2014, the After-Incident Review Working Group (AIRWG) delivered an After Incident Report. This management action plan addresses the report's recommendations in order to strengthen relevant national policies, guidelines and directives.

RECOMMENDATION 1

The CBSA "notification protocol regarding the death of an individual detained pursuant to the IRPA" should be revised to include notification procedures for cases of grave or serious injury of a person in custody. The updated protocol should be renamed appropriately and reissued by way of an operational bulletin.

MANAGEMENT RESPONSE

National Headquarters will review and update the protocol to include notification procedures for grave or serious injury.

MANAGEMENT ACTION PLAN

Update Operational Bulletin entitled *Notification protocol regarding the death of an individual detained pursuant to the IRPA (PRG-2014-51)* and issue amendment.

COMPLETION DATE

December 31, 2015

RECOMMENDATION 2

It is recommended the CBSA develop a medical information sharing agreement on a priority basis with Ontario as outlined in Schedules A and B of the current agreement; and, include medical information sharing provisions in other provincial agreements.

MANAGEMENT RESPONSE	
National Headquarters will work with Ontario Corrections to complete a medical information sharing agreement and include medical information sharing provisions in other provincial agreements as they are negotiated or re-negotiated.	

MANAGEMENT ACTION PLAN	COMPLETION DATE
Meet with Ontario Corrections to initiate discussions regarding a medical information sharing agreement.	December, 2015
Negotiate and finalize a medical information sharing agreement with Ontario Corrections.	March 31, 2016
Negotiate/Renegotiate and finalize provincial agreements which include provisions for sharing of medical information.	Ongoing

RECOMMENDATION 3

It is recommended that CBSA works with provincial correctional authorities to ensure sharing, in confidence and in a timely manner, of pertinent incident-related information that may impact CBSA Detention Program decision-making and policy development.

MANAGEMENT RESPONSE	
National Headquarters will engage provinces to seek collaboration in sharing, in confidence, relevant incident-related information.	

MANAGEMENT ACTION PLAN	COMPLETION DATE
Meet with Ontario Corrections to discuss disclosure of relevant incident-related information.	December, 2015
Negotiate and finalize the terms of disclosure with Ontario Corrections and update the current agreement consistent with annual agreement review cycle.	March 31, 2016
Negotiate/renegeotiate and finalize provincial agreements which include provisions for disclosure of relevant incident-related information.	Ongoing

RECOMMENDATION 4

It is recommended that staff be reminded of the need for independent note-taking and preparing notes in a timely manner. Previous shift briefings on this subject should be re-circulated nationally.

MANAGEMENT RESPONSE
National Headquarters Staff will issue a reminder to all front-line and enforcement staff the importance of timely and independent note-taking and provide context related to the recent incidents.

MANAGEMENT ACTION PLAN	COMPLETION DATE
Issue an Operational Bulletin and seek support via the National Inland Enforcement Committee for communication of the importance via shift briefings.	December, 2015

RECOMMENDATION 5

It is recommended that formal training be developed and provided to staff on suicide/self-injury and mental health awareness.

MANAGEMENT RESPONSE
National mental health training for staff working in CBSA immigration holding centres is under development.

MANAGEMENT ACTION PLAN	COMPLETION DATE
Develop and roll-out nationally an online course on "Prevention of Suicide and Self-Injury".	March, 2015
Continue working with Correctional Service of Canada to develop additional mental health training awareness tailored to immigration detention.	Ongoing



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OPERATIONAL BULLETIN: PRG-2014-50

TITLE: Immigration Detainee Transfers – Medical Information

Date of Issue: 2014-09-24	Mode(s): All	Target Audience: National	Area of Interest: Detention
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Details:

To ensure the safety and well-being of individuals detained under s. 55 of the IRPA, the CBSA is expanding the application of the *National Directive on the Transfer of Medical Information of Immigration Detainees* issued in 2011.

The purpose of this operational bulletin is to inform officers of the new requirement for completion of the Detainee Medical Form BSF 674 and to replace the previous national directive. The arresting or detaining officer must complete the BSF 674 once the decision is made to transfer an individual to an admitting detention facility. Examples of admitting detention facilities include RCMP detachments, Immigration Holding Centres, provincial jails and municipal jails.

Requirements when an individual is detained at an Immigration Holding Centre (IHC):

A new BSF 674 must be completed every 45 days after the initial completion as prescribed above or at any point prior to the 45 day requirement when a detainee self identifies a change in medical condition or when a possible change in medical condition is observed by any custodial staff.

Requirements when an individual is detained at a non-CBSA detention facility:

Prior to transfer to an IHC, every individual detained must have a BSF 674 completed by a CBSA officer. This would not be applicable if the transfer to the IHC happens within the first 45 days of detention, however, except in cases where a detainee self identifies a change in medical condition or when a possible change in medical condition is observed, the form must be completed.

CBSA officers do not have to complete a reassessment every 45 days while the individual is detained in a non-CBSA detention facility where a medical professional is present.

This OB does not apply when effecting an escort (e.g. hospital visit, hearing).

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Actions required:

Arresting / Detaining officer:

- Complete the BSF 674 prior to transporting the detainee to the admitting detention facility.
- Provide a copy of the BSF 674 to the CBSA officer responsible for the case. (e.g. inland enforcement officer, hearings officer, etc.)

When transporting:

- Retain a copy of the BSF 674 at all times during custody transportation of the detainee.
- Provide a copy of the BSF 674 to the admitting detention facility upon admission.

In cases where it is not possible to complete the BSF 674 at the time the decision is made to transfer the individual to an admitting detention facility, for example, in remote situations, the arresting or detaining officer must complete the BSF 674 as soon as practicable.

Transfers from a non-CBSA detention facility to an IHC:

- Prior to transfer to an IHC, every individual detained must have a BSF 674 completed by a CBSA officer. If the BSF 674 has not been updated within 45 days of the date of transfer, a new one must be completed. The original copy must be retained by CBSA and a copy should be provided to the on-site medical staff at the receiving IHC.
- In some cases this will require a CBSA officer to attend the admitting detention facility to complete the BSF 674 prior to transfer.

Transfers from an IHC to a non-CBSA detention facility:

- When a detainee is transferred from an IHC to a non-CBSA detention facility, the CBSA officer must validate the BSF 674 on file to ensure all current medical needs are identified prior to transfer. If the BSF 674 has not been updated within 45 days of the date of transfer, a new one must be completed.



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- A copy of the BSF 674 must be retained at all times during custody transportation of the detainee and a copy must be provided to the admitting detention facility upon admission.
- IHC medical staff or delegated personnel must ensure that the medical file is transferred to the non-CBSA facility as soon as possible.
- If special circumstances prevent the medical file from being transferred with the detainee, the medical file will be delivered, either in person or by fax, without delay to the non-CBSA facility.
- The BSF 674 form will include the contact details of the originating IHC from which the person is being transferred, allowing the non-CBSA facility medical staff to consult the IHC medical staff and/or emergency contacts should there be gaps or exceptional delays in receipt of the medical file.

The BSF 674 should be retained, at a minimum, on the individuals immigration case file and adhere to the Government of Canada's information retention policy.

Contact Information:

Hearings and Detentions Unit
Transformation Division
Enforcement and Intelligence Programs Directorate
Programs Branch

Any questions regarding this bulletin should be directed to the Hearings and Detentions Unit via the following email address at:

CBSA-ASFC Hearings Detentions-Audiences Detentions.

Approved by: Lesley Soper, A/Director General
Enforcement and Intelligence Programs Directorate
Programs Branch

Effective Date: 2014-09-24

Updated: N/A

Additional bulletins:



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OPERATIONAL BULLETIN: PRG-2014-51

TITLE: Protocol Regarding the Death of an Individual Detained Pursuant to the *Immigration and Refugee Protection Act*

Date of Issue: 2014-09-24	Mode(s): Detention facilities	Target Audience: National	Area of Interest: Detentions
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Introduction

This protocol has two parts. The first part provides instruction and operational guidance for Canada Border Services Agency (CBSA) staff and third-party service providers working within a CBSA Immigration Holding Centre (IHC) or providing transportation services. In addition, it provides guidance on situations where death occurs at a hospital, in a hearing room or any pre-hearing holding area, or during transfer between any of these aforementioned locations where an individual is under detention pursuant to the Immigration and Refugee Protection Act (IRPA). The second part of this protocol provides instruction and operational guidance for CBSA staff in situations where a death occurs in a federal, provincial or municipal correctional facility where the deceased was detained pursuant to the IRPA. In addition, protocols are provided should a death occur during a transfer between an IHC and a correctional facility.

Please be cognizant that this protocol does not apply in situations where death occurs at Port-of-Entry, during an inland investigation or within the removals stream pursuant to IRPA.

Definitions

Immigration detention is any detention pursuant to the Immigration and Refugee Protection Act (IRPA).

Immigration Holding Centres are CBSA-managed detention facilities currently located in Laval, QC; Toronto, ON; and Richmond, BC.

Federal, provincial or municipal correctional facilities are any government run correctional or detention facility where immigration detainees may be held.

Third-Party Service Provider is a vendor that has been awarded a Government of Canada contract to provide the specific services of security guards to assist CBSA in

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the daily management of the detention program.

Protocol for Incidents at the IHC

Canada Border Services Agency Responsibilities

CBSA officers:

1. CBSA officer who is first person on the scene:
 - Assume the responsibilities of the first person on the scene, as it relates to the application of first aid.
 - Contact emergency services (e.g. emergency medical technician [EMT], police, IHC medical staff, etc.)
 - Clear the area of other detainees and all non-essential personnel as soon as possible, while being mindful of the need to preserve evidence for any subsequent investigation. In some cases, this may include controlling or segregating individuals depending on the nature of death.
 - Take note of all persons present at the time of the incident.
 - Report the incident immediately to the appropriate CBSA official (e.g. manager or supervisor).
 - Complete a security incident report (BSF 152) at the conclusion and provide a copy to CBSA IHC manager or supervisor. Follow established procedures.
2. In an assisting role:
 - Follow all instructions provided by the individual providing first aid and assist wherever possible.
 - Assume scene management responsibilities from 3rd party service provider staff, if applicable.
 - Assist in clearing the area of other detainees and all non-essential personnel as soon as possible, while being mindful of the need to preserve evidence for any subsequent investigation. In some cases, this may include controlling or segregating individuals depending on the nature of death.
 - Take note of all persons present at the time of the incident.
 - Provide any other required supporting role to the individual first on the scene.
 - Complete a security incident report (BSF 152) at the conclusion and provide a copy to CBSA IHC manager or supervisor. Follow established procedures.



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3. The CBSA manager or supervisor will:

- Ensure that the appropriate emergency services were contacted (e.g. EMT, police, IHC medical staff, etc.) and if not, contact them immediately.
- Ensure that the scene is secure to preserve evidence (this can be delegated to another CBSA officer in situations where the CBSA manager or supervisor at the IHC is unable to be physically present in a timely manner following the incident).
- Brief regional senior management immediately following confirmation of death.
- Notify the Border Operations Centre (BOC) of a "significant event"-
 - Follow established procedures.
- Identify next of kin and notify the Regional Director General (RDG). This should be done as soon as possible following the confirmation of death.
 - In cases where there is an investigative body (e.g. local police or RCMP) involved. The notification of next of kin will be undertaken by them. The CBSA manager or supervisor must have confirmation from the investigative body that the notification of next of kin has taken place.
 - Notify the RDG once confirmation is received from the investigative body.

4. The RDG will:

- In cases where an investigative body is not undertaking the notification of next of kin (e.g. death as a result of natural causes); notify next of kin, this should be done in person, whenever possible.
 - For overseas notification the template notification to next of kin - overseas (appendix A) should be used.
- In cases where next of kin notification was not possible. The RDG must ensure that the Embassy and / or Consulate of the deceased country of citizenship is notified.
 - Always keep in mind the importance of not disclosing personal information beyond tombstone data or any particulars of the investigation or case to the authorities of the country of citizenship.

5. The BOC will:

- Notify required NHQ senior management of the "significant event".
- Notify the Communications Directorate of the "significant event".



Third-Party Service Provider Responsibilities

1. The third-party service provider staff, first on the scene, will be required to:
 - Assume the responsibilities of the first person on the scene, as it relates to the application of first aid.
 - Contact emergency services (e.g. EMT, police, IHC medical staff, etc.).
 - Clear the area of other detainees and all non-essential personnel as soon as possible, while being mindful of the need to preserve evidence for any subsequent investigation. In some cases, this may include controlling or segregating individuals depending on the nature of death.
 - Take note of all persons present at the time of the incident.
 - Report the incident immediately to the appropriate CBSA official (e.g. manager or supervisor).
 - When CBSA officers arrive on scene, defer scene management responsibilities and assist as required. This does not include the application of first aid.
 - Complete a security incident report (BSF 152) at the conclusion and provide a copy to CBSA IHC manager or supervisor. Follow established procedures
2. In an assisting role:
 - Follow all instructions provided by the CBSA officer; or third-party service provider staff or supervisor that is responsible for the scene.
 - Assist in clearing the area of other detainees and all non-essential personnel as soon as possible, while being mindful of the need to preserve evidence for any subsequent investigation. In some cases, this may include controlling or segregating individuals depending on the nature of death.
 - Take note of all persons present at the time of the incident.
 - Provide any other required support to the individual first on the scene.
 - Complete a security incident report (BSF 152) at the conclusion and provide a copy to CBSA IHC manager or supervisor. Follow established procedures

In cases where death occurs in a hospital, the third-party service provider must report the incident immediately to the appropriate CBSA officials and comply with all instructions provided by the hospital staff on site.



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Protocol for Incidents at a Federal, Provincial or Municipal Correctional Facility

Canada Border Services Agency Responsibilities

Upon receiving notification of the death of a detainee from the correctional facility:

1. The CBSA manager or supervisor will:
 - Brief regional senior management immediately following confirmation of death.
 - Notify the BOC of a "significant event" –
 - Follow established procedures.
 - Identify next of kin and notify the Regional Director General (RDG). This should be done as soon as possible following the confirmation of death.
 - In cases where there is an investigative body (e.g. local police or RCMP) involved. The notification of next of kin will be undertaken by them. The CBSA manager or supervisor must have confirmation from the investigative body that the notification of next of kin has taken place.
 - Notify the RDG once confirmation is received from the investigative body.
2. The RDG will:
 - In cases where an investigative body is not undertaking the notification of next of kin (e.g. death as a result of natural causes); notify next of kin, this should be done in person, whenever possible.
 - For overseas notification the template notification to next of kin – overseas (appendix A) should be used.
 - In cases where next of kin notification was not possible. The RDG must ensure that the Embassy and / or Consulate of the deceased country of citizenship is notified.
 - Always keep in mind the importance of not disclosing personal information beyond tombstone data or any particulars of the investigation or case to the authorities of the country of citizenship.
3. The BOC will:
 - Notify required NHQ senior management of the "significant event".
 - Notify the Communications Directorate of the "significant event".



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All CBSA employees and the third-party service provider staff are encouraged to cooperate with police, the coroner's office, medical examiner or any other investigative body in relation to incidents involving the death of a detainee in CBSA custody.

In cases where wrongdoing is suspected by an employee or third-party service provider they should be afforded the right to instruct counsel and/or their union representative prior to providing any information.

For more information please consult [Legal Assistance and Indemnification for CBSA Employees – Guidelines and Procedures](#)

Appendix A: [Template notification to next of kin – overseas](#)

Contact Information:

Hearings and Detentions Unit
Transformation Division
Enforcement and Intelligence Programs Directorate
Programs Branch

Any questions regarding this bulletin should be directed to the Hearings and Detentions Unit via the following email address at:

[CBSA-ASFC Hearings Detentions-Audiences Detentions](#)

Approved by: Lesley Soper, A/Director General
Enforcement and Intelligence Programs Directorate
Programs Branch

Effective Date: 2014-09-24**Updated:** N/A

Additional bulletins:



Canada Border Services Agency
Agence des services frontaliers du Canada

Notification to Next of Kin – Overseas

Date XXXX

Issue City, Province

Canada Border Services Agency

Dear (Name of Next of Kin),

It is with profound regret that I must confirm the death of your (relationship), (Name of deceased) on (date of death) in (place of death). On behalf of the Canada Border Services Agency and the Canadian Government, please allow me to extend my condolences to you and your family in your bereavement.

The Canada Border Services Agency in (city) learned of your (relationship's) death on (Date) at (location). (provide brief explanation of the circumstances of the death. If the cause of death is not yet determined, provide explanatory paragraph: Medical authorities have not yet determined the cause of your (relationship's) death.) (If applicable) In accordance with Canadian law, an investigation will take place. The Canadian Government will update you on the circumstances of your (relationship's) death as soon as more information becomes available.

Please do not hesitate to contact (name of CBSA representative, name and title) in (city, country) at (phone number including country code and area code) should you have any further questions.

Again, please accept my sincere condolences to you and your family.

Sincerely,

CBSA Representative



Canada Border
Services Agency

Agence des services
frontaliers du Canada

Border Services



Services frontaliers

OPERATIONAL BULLETIN: PRG-2014-52

TITLE: National Risk Assessment for Detention (NRAD) – BSF 754

Date of Issue: 2014-09-24	Mode(s): All	Target Audience: BSO, IEO, Hearing Officers, IHC Third-Party Service Providers	Area of Interest: Detention Continuum
-------------------------------------	------------------------	--	---

Background:

In efforts to ensure the safety and well-being of individuals detained under s. 55 of the *Immigration and Refugee Protection Act* (IRPA), the CBSA is implementing a National Risk Assessment for Detention (NRAD) tool – BSF 754. The intent of the BSF 754 is to improve national consistency and enhance the overall management of the detention program in a transparent and equitable fashion. This initiative also defines, for the first time, CBSA definitions of detainee risk.

Details:

The purpose of this operational bulletin is to inform officers of the new requirement for completion of the NRAD; this will be done at two points. First, the BSF 754 will be completed at the point an officer physically detains or arrests an individual pursuant to IRPA. Second, a new BSF 754 must be completed every 45 days after the initial completion as prescribed above or at any point prior to the 45 day requirement when a possible change in risk is observed by any individual within the detentions continuum. This approach will assist in a consistent decision making process when an officer detains an individual pursuant to the IRPA.

Actions required by operational staff:

The chart below is meant to assist officers in making an informed decision on detention based on a set of factors categorized by level of risk. Although factors may fall into a specific category of risk, all elements must be considered in their entirety in making a risk-based decision. In addition, given the evergreen nature of risk-based assessments, should new evidence be received to suggest that the assessed risk level may have changed, a reassessment should be completed as soon as possible.

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The level of detail contained in the narrative on form BSF 754 is crucial to supporting the Officer's decision.

CBSA Term	CBSA Definition
<p>High Risk -</p> <p>Recommendation: Detained in Provincial Facility or IHC where risk can be mitigated</p>	<ul style="list-style-type: none"> ▪ Security as defined in <u>A34</u> of the IRPA (and includes individuals subject to security certificates*) ▪ Human or international rights violations as defined in <u>A35</u> of the IRPA ▪ Serious criminality as defined in <u>A36(1)</u> of the IRPA ▪ Organized criminality as defined in <u>A37</u> of the IRPA ▪ Existence of a danger opinion – or a danger opinion is in progress ▪ Danger to the public ▪ Individual is at immediate risk of suicide ▪ Existence of an international warrant** <p>These individuals may have a record of violent crime or violent behavior and pose a significant escape risk (e.g. attempted escape from facility or other centers). The CBSA may inquire into reasonable suspicion of allegations of these inadmissibilities -<u>A58(1)(c)</u>-, may be pursuing the allegations, or they may be founded by the Immigration and Refugee Board. Individuals may have also demonstrated violent behavior at the IHC.</p>
<p>Medium Risk -</p> <p>Recommendation: Detained in IHC or Provincial facility where no IHC exists</p>	<ul style="list-style-type: none"> ▪ Minor criminality as defined in <u>A 36(2)</u> of the IRPA ▪ Criminality or security concerns may exist ▪ Individual has known or probable mental health issues ▪ Flight risk (i.e., removal is imminent) ▪ Identity concerns ▪ Individuals where high risk factors can be mitigated <p>These individuals may have a history of criminality (nature of offence not considered a danger to the public) or mental health issues (including suicide or self-harm). Individuals may also have behavioral issues that need to be monitored to determine whether risk escalates to a point where</p>



- 3 -

	detention in a provincial facility may be required.
Low Risk - Recommendation Released under terms and conditions	<ul style="list-style-type: none"> ▪ Vulnerable populations (i.e., pregnant women, senior citizens, victims of human trafficking, and minors) with no apparent risks ▪ Refugee claimants with no apparent risks ▪ Individuals where other risk levels can be mitigated <p>These individuals may be released into the community under terms and conditions (i.e. reporting requirements, cash bond, performance bond, telephone reporting or Toronto Bail Program) as there are no significant aggravating factors or where high / medium risk factors can be mitigated.</p>

*Individuals subject to security certificates are subject to the Federal Court's jurisdiction. The location of detention is to be determined on a case-by-case basis.
**Individuals subject to an international warrant are subject to the RCMP jurisdiction. Detention under IRPA should only be used in cases where the RCMP are unable to enforce the warrant.

Contact Information:

Hearings and Detentions Unit
Transformation Division
Enforcement and Intelligence Programs Directorate
Programs Branch

Any questions regarding this bulletin should be directed to the Hearings and Detentions Unit via the following email address at:

CBSA-ASFC Hearings Detentions-Audiences Detentions.

Approved by: Lesley Soper, A/Director General
Enforcement and Intelligence Programs Directorate
Programs Branch

Effective Date: 2014-09-26

Updated: N/A



Canada Border
Services Agency

Agence des services
frontaliers du Canada

News Release

For Immediate Release

Death of a CBSA detainee

September 28, 2014 Niagara Falls, Ontario

Canada Border Services Agency

On September 22, 2014, first responders were called to the Niagara Detention Centre in Thorold and an adult male detainee was sent to a local hospital. The man passed away in hospital on September 27, 2014.

Family of the deceased have been notified. The man's identity will not be released at this time.

As in all cases of in-custody deaths, the police and the coroner have been notified. The CBSA will also be reviewing the circumstances of the incident.

The CBSA is not in a position to release further information while the investigation is ongoing.

Associated Links

[Overview of the CBSA's Immigration Detention Program](#)

[Information for People Detained Under the *Immigration and Refugee Protection Act*](#)

[Arrests and detentions](#)

Contact

Canada Border Services Agency
Media Line

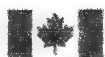
613-957-6500 or questions@cbsa-asfc.gc.ca



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After Incident Report

Incident at the B.C.
Immigration Holding
Centre

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Annex 1: *Regional Due Diligence Report*

Background

1. Overview of the CBSA's Immigration Detention Program

In order to protect the safety, health and security of Canadians and the integrity of our border, the *Immigration and Refugee Protection Act* ("IRPA") permits the CBSA to detain individuals.

Pursuant to the IRPA, detention can occur when:

1. A CBSA officer has reasonable grounds to believe that the person is inadmissible and:
 - could pose a danger to the public;
 - is unlikely to appear for immigration proceedings; or
 - identity has not been established.
2. A CBSA officer has reasonable grounds to suspect, at a port of entry, that the person is inadmissible for security reasons, violating human or international rights, serious criminality, criminality or organized criminality.
3. It is necessary to complete the immigration examination.
4. A foreign national is designated as an irregular arrival by the Minister of Public Safety.

People are detained in either a CBSA-run Immigration Holding Center ("IHC") or a provincial correctional facility. The CBSA relies on provincial correctional facilities to hold higher-risk detainees (i.e., criminal background) and lower-risk detainees in areas not served by an IHC. In British Columbia, the IHC is located within Vancouver International Airport and is used only as a short term facility.

For the operation of its IHCs, the CBSA maintains national detention standards that conform, to the greatest extent possible, with international protocols. National detention standards include, for example, a daily minimum of one hour open air exercise, free local telephone calls, access to a qualified religious representative upon request, and special meals provided for medical, dental or religious reasons.

Detainees have access to medical services as required and as a result of their detention, qualify for the Interim Federal Health Program if unable to pay for essential treatment, or are otherwise covered under provincial health care programs.

Program Integrity and Independent Monitoring

The CBSA maintains national standards for program integrity and oversight of its detention program. Its quality assurance program, as well as numerous internal and external audits and evaluations, ensures that the CBSA consistently strives to meet the highest detention standards and international protocols.

The Canadian Red Cross, an independent and non-profit organization, monitors immigration detention conditions in each CBSA facility, as well as in correctional facilities in several provinces pursuant to a Memorandum of Understanding with the CBSA, to ensure that national standards and international

obligations are met to the fullest extent possible. In fiscal year 2012-13, the Red Cross visited the CBSA BCIHC 4 times and, 2 times in fiscal year 2013-14. The Red Cross presents its observations to the CBSA in a confidential annual report.

At the same time, the CBSA regularly consults stakeholders and NGOs, such as the UNHCR, about detention issues and takes their recommendations into account as a means to continuously improve detention conditions.

2. Overview of CBSA Detention Facilities

The CBSA retains responsibility for all CBSA operations of its detention facilities. However, private security companies are contracted by the CBSA to provide security guard and transportation services including but not limited to:

- The care and control of persons detained under the *Immigration and Refugee Protection Act* (IRPA) at a CBSA IHC;
- The management and provision of the safe and secure transportation of detainees to and from the IHC;
- The accompaniment of detainees to ports of entry for their removal and/or to verify their departure from Canada; and
- The performance of other security duties as required by the CBSA.

Determining Suitable Facilities

A person who is detained may be held in a provincial correctional facility or in an IHC that is administered by the CBSA. In general, the CBSA relies on provincial correctional facilities to detain higher-risk individuals. Where appropriate and practicable, lower-risk detainees will be held at a CBSA IHC.

CBSA officers and management consider a variety of factors to determine if an individual is suitable for a lower or higher-risk facility. These factors include behaviour, medical needs, mental health issues, criminality, impairment, and/or a history of violence or substance abuse.

British Columbia Immigration Holding Centre

The CBSA operates one short term detention facility in Vancouver, British Columbia – the British Columbia Immigration Holding Centre (BCIHC) – located in the Vancouver International Airport, which is authorized to hold a maximum of 24 individuals for detentions of under 72 hours.

Individuals held in the BCIHC are awaiting removal, awaiting transfer or recently arrested and detained under the IRPA.

In the BCIHC, clients have access to:

- Telephones: Detainees are free to make local calls (at no cost), including to legal counsel and consulate officials, between 6 a.m. and 11 p.m.. After hours calls are approved at the discretion of

the Manager of Detention Operations. Detainees also have the ability to make collect long distance calls. Special time arrangements can be made to accommodate overseas calls.

- Legal counsel: An individual may request access to legal counsel in person or over the phone at any point in time in the detention process.
- Duty counsel: Any individual may obtain free legal services in detention from duty counsel.
- CBSA Detainee Liaison Officer (DLO): The DLO is available to follow up on requests, complaints, and to answer questions about the immigration process for individuals in detention. The DLO is available by phone from any facility in the area and they conduct regular site visits.
- Medical services: Medical personnel are accessible 24/7 and all officers and guards are trained in first aid.
- Religious Services: Accommodations can be made for an individual in detention to practice his or her religion.
- Facilities: Between the hours of 06:00-23:00 cell doors are open and individuals have access to showers, a common area, and washrooms. Each cell includes a toilet, wash basin and water fountain.

Due to the secure location of this facility, visitor access – other than legal counsel and independent human rights groups – is restricted.

British Columbia Provincial Detention Facilities:

When an individual is detained for a period over 72 hours or if they are deemed to be unsuitable for detention at the BCIHC, they are placed in provincial facilities.

3. Summary of Incident

On December 1, 2013, Ms. Lucia Dominga Vega Jimenez, a citizen of Mexico, was taken into custody by the CBSA for returning to Canada without authorization after she was arrested by the South Coast British Columbia Transportation Authority Police Service for fare evasion.

She was taken directly to the British Columbia Immigration Holding Centre (BCIHC) after her arrest and was held there until being transferred to the Alouette Correctional Centre for Women on December 4, 2013. On December 19, 2013 she was returned to the BCIHC in order to facilitate her removal from Canada, scheduled for December 22, 2013.

While awaiting deportation Ms. Vega Jimenez attempted suicide on December 20, 2013 and died in hospital as a result of her injuries on December 28, 2013.

Upon notification to senior management of the December 20, 2013 incident at the BCIHC, a formal process was undertaken to provide information to external stakeholders that included notifying the Canadian Red Cross, the Mexican Consulate, the Royal Canadian Mounted Police (RCMP) and British Columbia Corrections.

The RCMP commenced a criminal investigation and concluded on January 28, 2014 that no criminal offence (criminal negligence) had occurred. The B.C. Coroners Service is also investigating and on February 25, 2014 announced it would hold a public inquest relating to the death of Ms. Jimenez.

Following the incident, Pacific Region immediately initiated an internal review of its operations which included the establishment of a Post-Incident Working Group. The working group was established to assist in identifying procedural and infrastructure improvements to strengthen the detention program at the BCIHC (Annex 1 – *Regional Due Diligence Report*).

In addition, a national CBSA Directors General-led After Incident Working Group was established to review incident response, identify any operational, policy, procedural, infrastructure and training gaps and to recommend and implement changes where required. The following report and recommendations document the results of the review. Overall this report is intended to strengthen the CBSA's framework, procedures and practices for detention.

Note: A detailed case chronology, including facts surrounding the incident is outlined in the *Regional Due Diligence Report* (Annex 1) prepared by Pacific Region.

Key Observations and Recommendations

Assessment Against Existing Policy Instruments:

The CBSA's national policy instruments in relation to detention of persons held under the *Immigration and Refugee Protection Act* are: the detention manual (ENF 20) and the national detention standards. These national instruments serve to guide each immigration holding centre (IHC) in the development of specific (regional) operating procedures, providing detailed explanations of how the national policies are to be implemented. The regional operating procedures specific to the BCIHC in this document are referred to as standing orders.

In the context of the events surrounding the incident which led to the death of Ms. Vega Jimenez, it appears the engaged standing orders aligned with the national policy instruments.

The observations and recommendations are made based on the review of the *Regional Due Diligence Report* (Annex 1), and discussions stemming from the national CBSA Directors General-led After Incident Working Group. They are grouped under the following categories:

- Security Contract
- Infrastructure
- Procedures / Training

Observations and Recommendations:

Security Contract

Security services at the BCIHC are provided by Genesis Security Group, a third-party service provider. Security staff employed by Genesis Security are responsible for 24/7 monitoring of the detainees held in the CBSA BCIHC. The CBSA is ultimately responsible for the care and control of detainees: As such, the Region establishes facility-specific standing orders that are aligned with the national detention standards and ensures compliance with those standards in day-to-day operations.

Observation #1:

Immediately following the incident, the BCIHC reaffirmed the requirement that a minimum of two Genesis security guards be onsite at all times including a guard of each gender. This practice along with appropriate guard to detainee ratios (outlined in the national detention standards) both onsite at the IHC and on transportation duty of detainees are not covered in the current contract. The contract does not clearly outline expectations in this respect nor does it identify consequences for non-compliance with security contract requirements.

Recommendation #1:

Security and Professional Standards and Pacific Region should review the existing contract in its entirety and make appropriate changes to ensure precision on CBSA requirements and expectations consistent with the national detention standards and standing orders.

Infrastructure

Observation #2:

A number of security and safety concerns related to the BCIHC's physical infrastructure were identified as a result of direct observations made by Pacific Region in consultation with working group members established soon after the incident. The working group consisted of CBSA staff at the Pacific Region Inland Enforcement Section responsible for the BCIHC, personnel from similar facilities across Canada, Regional Security, and other stakeholders such as Infrastructure and Environmental Operations Directorate and Security and Professional Standards Directorate. Physical infrastructure items of concern identified as directly related to the incident have already been corrected. Other items that present security and safety concerns of general order were also identified.

Recommendation #2:

It is recommended that security and safety concerns identified in this report which are not directly related to the incident be addressed on a priority basis as funding becomes available or as part of the fit-up process.

Procedures and Training

Observation #3:

Prior to the incident, the CBSA visited the BCIHC on a bi-weekly basis to ensure management oversight of operations delivered by Genesis Security. Since the incident, the Region has implemented weekly visits to BCIHC by the Detainee Liaison Officer (DLO) in addition to other measures outlined in the *Regional Due Diligence Report* (i.e., review of logs and CCTV footage). In other IHCs CBSA is present onsite during the work week and on call at other times.

Recommendation #3:

The Region should further strengthen CBSA management oversight of the security contract and BCIHC operations. While CBSA officers interact almost daily with Genesis Security staff at the Pacific Region Inland Enforcement Section when detainees are transported there for interviews and hearings, regular and more frequent visits to the BCIHC would allow for onsite monitoring of detention conditions and operations and identify issues early that may require corrective action. It is recommended that the DLO's roles and responsibilities with respect to the weekly visits be clearly outlined and documented in writing. It is further recommended that CBSA regional management increase the number of meetings with Genesis Security management and, meet on a regular basis to review contract requirements against performance.

Observation #4:

There is no indication that the existing BCIHC standing orders (dated 2009) were reviewed or updated on an annual basis as outlined in the national detention standards.

Recommendation #4:

Pacific Region must review and update the current standing orders on a priority basis, and identify gaps and develop additional standing orders where required. Standing orders ensure respect of the national detention standards and provide guidance on expectations related to facility operations.

Observation #5:

Although the national detention standards explicitly state that security guards must successfully complete training in First Aid and CPR, use of restraint equipment, tactical certification and dealing with disruptive behavior, in addition to training on cultural awareness, harassment and relevant IRPA provisions, they do not explicitly state that training in suicide and self-injury prevention is required. "Suicide Prevention Awareness" is a stand-alone item under the requirement for security guards. In the absence of clear language on expectations, guards are generally provided with printed reference material on the subject.

Recommendation #5:

It is recommended that the future security service contract in the Pacific Region should include a requirement that guards assigned to the IHC receive approved training in suicide and self-injury prevention.

Conclusion

Operations, Programs and Comptrollership branches are working closely to ensure implementation of the recommendations in 2014-2015.

Lesley Soper
A/Director General
Enforcement and Intelligence Directorate
Programs Branch

Pierre Giguère
Director General
Security and Professional Standards Directorate
Departmental Security Officer
Comptrollership Branch



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Regional Due Diligence Report

*Summary of the facts surrounding
the in-custody death of
Lucia Dominga VEGA JIMENEZ*



January 21, 2014

Prepared by:

PROTECTION • SERVICE • INTEGRITY

Canada



A/Chief Doug Mossey
Enforcement & Intelligence Division

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Analysis – BCIHC Facility and the Guards

68. At the time of the incident, there was one supervisor physically located at the BCIHC and two more guards offsite, for a total of three Genesis guards on shift. This falls below the standard of four set out in the contract and Standing Orders. Additionally, there was no female guard on site, another requirement of the contract and Standing Orders.
69. VEGA JIMENEZ was last captured on camera entering the shower room at around 06:08 hours and was not seen again until Supervisor [redacted] entered the shower room and discovered her hanging from the shower curtain rod at approximately 06:50 hours. This indicates she was not checked on for approximately 42 minutes, despite the Standing Order stipulation that detainees are to be checked every 30 minutes. It appears from the Room Checks List that gaps in excess of 30 minutes occurred five other times on the evening of December 19 and into December 20, with the longest being approximately 50 minutes.
70. Once discovered, VEGA JIMENEZ received immediate medical attention including the use of CPR and an AED. Paramedics were on scene within approximately 8 minutes. Both supervisor [redacted] direct supervisor and the CBSA Acting Manager in charge of the facility, Christian Lane, were informed about the incident as soon as practicable. The response to having found VEGA JIMENEZ was in keeping with the emergency procedures outlined in Standing Order #15.

Conclusion

71. The CBSA followed normal procedures in immigration proceedings against VEGA JIMENEZ. She was provided with her *Charter* and Vienne Convention rights upon her arrest, had a report written



against her which was reviewed by a Minister's Delegate to insure it was valid, received an immediate detention review followed by one at 48 hours and another at seven days and was advised of her right to apply for PRRA.

72. There is no indication that any CBSA employee or Genesis guard was aware she was at risk for self-harm.

There does not appear to be any indication from any of those contract employees that she was at risk for self-harm.

73. The day of the incident that ultimately resulted in the death of VEGA JIMENEZ, the Genesis guards did not meet the typical staffing level as per the contract and Standing Orders and they did not check on her within the times specified by the CBSA. Specifically, there was only one male staff member at the BCIHC at the time of the incident and she was not checked on for approximately 42 minutes.



Appendix 1: Outstanding Investigative Steps

The following steps were undertaken to assist in the writing of this report:

- Detailed review of VEGA JIMENEZ's immigration history, including a review of the physical file and computer-related databases
- Interviews with Enforcement and Intelligence Division staff that had contact with VEGA JIMENEZ in December 2013
- Interviews with current Manager and past Manager responsible for the BCIHC
- Interview with Detention Liaison Officer
- Review of the Pre-incident Chronology and updated Issue Fact Sheet
- Review and analysis of the current contract for security services at BCIHC and accompanying Annexes and Standing Orders
- Review of the BCIHC Sign in Log and Room Checks List for December 20, 2013
- Review of Security Services file, including notes, interviews and photographs taken at BCIHC
- Review of available Security Incident Reports
- Review of suicide awareness related training materials and documents for BCIHC staff
- Review of CCTV footage
- Physical tour of BCIHC facility

The following steps were not undertaken and are recommended should further investigation be deemed warranted:

- **Interview CBSA contract employees.** The following Genesis Security Group employees were on shift when VEGA JIMENEZ was present at BCIHC on December 19 and December 20:
 1. (Genesis site supervisor)
 2. (December 19 and 20)
 3. (December 19 and 20)
 4. (December 19 and 20)
 5. (December 19 and 20)
 6. (December 19 and 20)



7. (December 19 and 20)
8. (December 19)
9. (December 19)
10. (December 20)

- **Interview persons not employed by the CBSA.** The following persons were in contact with VEGA JIMENEZ in December 2013:

1. (Mexican Consulate Vice Consul)
2. (fellow detainee)
3. (fellow detainee)
4. (fellow detainee)
- 5.
6. ACC correctional staff members
7. Other detainees house with VEGA JIMENEZ at the ACC

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Appendix 2: Recommendations

Based on foregoing Due Diligence Report, the following recommendations are proposed:

- **Recommendation #1: Effective immediately, introduce a requirement that a minimum of two (2) Genesis guards be physically present on site at all times at the BCIHC.** Currently, the contract and accompanying standing orders are not clear on staffing levels at the facility itself. While the contract sets "typical" staffing at three (3) guards and one (1) supervisor and Standing Order #3 states that four (4) line officers are to be provided, with one (1) being a supervisor, neither explicitly state a requirement to be physically present at the facility. Therefore, while the provisions that there should be four (4) guards on shift should remain, Standing Order #3 should be re-written to explicitly state that at least two (2) guards, one of each gender, will remain physically present at BCIHC at all times, without exception.

Note: Immediately following the incident on December 20, 2013, Acting Manager Christian Lane implemented the following:

- *A two-guard minimum to be physically present at all times at the BCIHC*
- *At least one male and one female physically present at all times at the BCIHC*
- **Recommendation #2: Effective immediately, introduce a ratio of guard-to-detainee set at minimum of one guard (1) for every five (5) detainees at the BCIHC.** This recommendation is meant to compliment the first recommendation: while still maintaining a minimum of two (2) guards at all times at the BCIHC, there should also be a ratio introduced within Standing Order #3 that states the ratio of detainee-to-guard never exceeds 5:1.

Note: Acting Manager Christian Lane has advised that BCIHC procedures are currently under review, including assessment of whether a ratio of guard-to-detainee should be established.

- **Recommendation #3: Effective immediately, ensure that guards at the BCIHC are conducting physical checks and that such checks are occurring at least every 25 minutes.** Although Standing Order #21 states that there is to be a check of each detainee every 30 minutes, it



appears that this is not what occurred on December 20, 2013. CBSA oversight of this requirement is warranted; therefore this recommendation should be the responsibility of the Manager, Regional Programs (Detentions) or another suitable CBSA manager. Furthermore, the acceptable time should be reduced from 30 minutes to 25 minutes, to ensure the randomness in intervals and avoid becoming predictable to the detainees.

Note: Immediately following the incident on December 20, 2013, Acting Manager Christian Lane implemented the following:

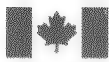
- *Each detainee is visually checked on three times per hour at random intervals*
- *The DLO is to ensure such checks are being conducted by reviewing a daily log*
- **Recommendation #4: Effective as soon as possible, remove the blinds covering the windows in the control room and replace the glass with a one-way mirrors.** This will assist the guards in their 25 minute checks and also increase safety at the facility, while not reducing the integrity of the control room or reducing the privacy of the guards.
- **Recommendation #5: Effective as soon as possible, remove the shower curtain rod and replace with a break-a-way shower curtain system.** Such a system can be mounted above the shower opening and attached to a curtain using continuous loop tape. There are no hooks, pins or rods to such a system.
- **Recommendation #6: Effective as soon as possible, conduct of full review of the BCIHC facility to address other potential hazards.** In addition to the shower curtain rod, there are other objects that could be used to assist in a suicide-by-hanging. Such items include door handles, metal bars and tables. A full review should be undertaken to determine what, if anything, can be done to minimize these risks. Such a review will likely involved engaging B.C. Corrections and other external partners.
- **Recommendation #7: Effective as soon as possible, increase CBSA oversight at the BCIHC.** This recommendation should include an increased presence by CBSA employees at the BCIHC as well as more off-site oversight, such as remote monitoring of the cameras and periodic review of



the performance of the guards at set intervals. Currently, the Detention Liaison officer is on-site at the BCIHC for approximately half a day, every two or three weeks. In addition to increasing those hours, other options should be considered. This could include engaging CBSA personal that are on duty twenty-four hours a day at VIA or perhaps staffing a position on a part-time basis. The camera set up at BCIHC is adequate; however the ability to retrieve the archived footage is a cumbersome process. Therefore, the technology should be brought up to date to ensure the reviewing manager can easily access the information to assist in performance reviews. Ideally, the manager would be able to retrieve this information remotely. All video reviewed should be compared to the logs completed by the guards to ensure what is being reported is what is actually occurring, and any anomalies should be addressed immediately.

Note: Acting Manager Christian Lane has advised that the BCIHC facility is currently under review by a working group and each of the four Recommendations #4 through #7 above are included in that review.

Although these recommendations are based on the BCIHC facility itself, they may be applicable to the day cells at Library Square as well (Library Square day cells were not specifically reviewed).



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In Custody Death
After Incident Review
Abdurahman Ibrahim Hassan

Completed by the
Greater Toronto Area Region

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**Version Control Page**

VERSION	DATE	CHANGES
1.0	June 26, 2015	Initial report to Vice-President's office.
1.1	July 2, 2015	<p>Updated with formatting and grammatical changes.</p> <p>Updated to address comments from Associate Vice- President (AVP), Operations Branch:</p> <ul style="list-style-type: none"> • Details on health issues highlighted in opening Incident Summary. • Recommendations section modified to include 1) National Considerations and 2) Regional Considerations. • Moved Case File – Chronology to Appendix A • Clarification on media release dates provided in Events Leading to Hospitalization section.
1.2	July 9, 2015	<p>Updated to include version control tracking page.</p> <p>Updated with minor grammatical changes.</p> <p>Updated to address comments from AVP, Operations Branch.</p> <ul style="list-style-type: none"> • Merged Conclusions and Recommendations sections into Analysis and Recommendations section. <p>Updated to address comments from Executive Vice- President.</p> <p>Modifications made to Removals Efforts chronology to clarify CBSA follow up actions.</p>
1.3	August 12, 2015	Approved by the Incident Management Working Group.



Incident Summary

On

Abdurahman Ibrahim HASSAN



Current Status

The SIU is conducting their own investigation, as a member of the PPS and the OPP were overseeing Mr. Hassan at the time of death. The objective of every SIU investigation is to determine whether there is evidence of criminal wrongdoing on the part of the police. It is not to determine whether the involved officer(s) may have committed some lesser offence, such as the breach of a provincial law or professional misconduct under the *Code of Conduct* of police officers.

The MCSCS which is responsible for managing CECC, is also conducting their own investigation into this matter.

The Ontario Office of the Chief Coroner will complete a post-mortem or death investigation. As of June 17, 2015, the CBSA had not yet been notified by the Chief Coroner of the results of the death investigation, or notified when and if the inquest will be held.

The PRH is conducting their investigation in concert with the Coroner's office.



Analysis and Recommendations

External Agency Engagement

The CECC is located in Lindsay, Ontario, approximately 140 kilometers (km) from the Toronto Pearson International Airport. It opened in February 2003, and is operated by the Ministry of Community and Correctional Services (Province of Ontario). It is a medium/high security facility that has a capacity of 1148 persons, both male and female, in a six-unit structure. The authority of any correctional institution to hold a person detained under the provisions of IRPA is located in section 143 of the IRPA. It is responsible for holding persons on remand (awaiting trial, segregation, sentencing or proceedings), offenders sentenced to short terms of two years or less and offenders awaiting transfer to a federal or provincial correctional facility.

The CECC is the main institution for high risk CBSA detainees, which currently accommodates 115 of our 215 provincial detainees. When a detainee is considered high risk they do not meet the criteria for detention into the TIHC. The TIHC is operated by the CBSA in the GTAR. High risk detainees are housed within a provincial facility.

The CBSA staffs a casual clerical position at the institution as an on-site liaison, and an IEO stationed at the TIHC plays a more formal role as liaison (JLO) with all provincial facilities.

Overview of CBSA Memorandum of Agreement to Provide Detention Service

Detention services are currently covered under the Memorandum of Agreement (MOA) between the CBSA and MCSCS that was signed in January 2015, and retroactive to April 1, 2013. This agreement covers the reciprocal exchange of information regarding inmates and persons under correctional supervision who are other than Canadian citizens in general.

According to this MOA, the MCSCS is to notify the CBSA immediately when an individual is taken to the hospital and that as soon as possible, or within 24 hours, CBSA contract guards are to relieve Corrections officials. The terms of the MOA, Article 2.12 specifies:



Ontario shall be responsible for the supervision and security of the persons detained pursuant to this Agreement while in hospital until Canada assumes custody. Canada shall assume custody of the persons detained pursuant to this

Agreement as soon as possible but in any event within 24 hours of notification of the transfer by Ontario.

Communication Protocol between the CBSA and Central East Correctional Centre

The MCSCS and CBSA have an established communication protocol in place when the health and welfare of a detainee on immigration hold in a provincial correction facility is affected. During regular business hours, MCSCS officials contact the CBSA IEO who is responsible for maintaining the day to day interaction between the CBSA and the various provincial correctional institutions where immigration detainees are held.

After business hours, MCSCS officials have been advised to contact the CBSA inland enforcement duty manager with any information on the status of immigration detainees in provincial correctional facilities.

During this incident, both when Mr. Hassan was initially hospitalized and subsequently following his passing, CBSA officials were not advised in a timely fashion of these incidents.

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MANAGEMENT RESPONSE AND ACTION PLAN FOR THE INCIDENT AT THE PETERBOROUGH GENERAL HOSPITAL (NDC)

OVERALL MANAGEMENT RESPONSE

As a result of the incident at the Peterborough General Hospital on June 11, 2015, the Greater Toronto Area Region initiated an internal review of its operations to assist in identifying procedural improvements to strengthen the detention program in the Greater Toronto Area Region.

The national CBSA Directors General-led After Incident Working Group reviewed the regional review titled "*In Custody Death After Incident Review Abdurahman Ibrahim HASSAN*" resulting in the approval of three recommendations. The recommendations and actions taken are intended to strengthen the CBSA detention procedures and practices.

RECOMMENDATION 1

The GTAR will revisit with Ministry of Community Safety and Correctional Services (MCSCS) officials, the established communication protocols ensuring that there is direct contact between officials during health and welfare or other incidents involving immigration detainees in provincial correctional facilities; reinforcing that timely notification is essential.

MANAGEMENT RESPONSE

Regional management will issue a reminder to MCSCS staff and to CBSA staff in regards to the communication protocol to alert CBSA employees when an immigration detainee is transferred from a correctional facility to a hospital in a timely manner.

MANAGEMENT ACTION PLAN		STATUS	COMPLETION DATE
1.1	Re-issue a reminder to MCSCS superintendents the communications protocol outlined in the Ontario/CBSA MOA that the CBSA must be of a detainees transfer to hospital from a correctional institution as soon as possible. The superintendents will ensure the reminder is disseminated to all MCSCS staff.	Completed	October 13, 2015
1.2	The Greater Ontario Area Region will provide MCSCS an updated contact list of CBSA personnel to contact when a detainee is transferred to a hospital facility.	Completed	October 13, 2015

September 23, 2015

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RECOMMENDATION 2

Once the CBSA is notified by MCSCS officials that a person detained for Immigration purposes is being admitted to a hospital, arrangements will be made pursuant to the terms of the MOA to transfer custody from the provincial facility to a hospital. These updated procedures reinforce the requirement for CBSA officials to take custody of persons transferred in these circumstances within 24 hours.

MANAGEMENT RESPONSE
The Greater Toronto Area Region will ensure that Transfer of Custody protocols between the CBSA and the MCSCS take place as soon as possible and within 24 hours when a detainee is transferred from a provincial correctional facility to a hospital and again once the detainee is released from hospital.

MANAGEMENT ACTION PLAN	STATUS	COMPLETION DATE
2.1 The Greater Toronto Area Region will communicate in writing to MCSCS superintendents the requirement to complete a Transfer of Custody of a detainee when they are moved from a correctional facility to a hospital as per the MOA (section 2.11 and 2.12). The superintendents will share this information with all correctional staff. Security staff at the IHC will also be apprised of this requirement.	Completed	August 13, 2015
2.2 The Greater Toronto Area Region will remind CBSA employees to ensure a new Detention Order is completed once a detainee is released from hospital and transferred back to a provincial correctional facility. Security staff at the IHC will also be notified that a signed Detention Order must be presented to MCSCS staff upon transfer from a hospital to a correctional facility.	Completed	August 13, 2015

September 23, 2015



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RECOMMENDATION 3

The CBSA will explore Alternatives to Detention, particularly for persons dealing with mental health issues and vulnerable populations.

MANAGEMENT RESPONSE

Detentions Programs at HQ will continue to develop an Alternatives to Detention (ATD) Program that focuses on the expansion of current ATD options to allow for the consistent and effective management of individuals in the community.

MANAGEMENT ACTION PLAN	STATUS	COMPLETION DATE
3.1 - Detentions Programs will research, meet and collaborate with potential partners to complete an Alternatives to Detention business case, particularly for persons dealing with mental health issues and vulnerable persons.	In progress	March 31, 2016

September 23, 2015